

CASE INVESTIGATION FORM: MONKEYPOX
PATIENT DETAILS

Surname:		Name/s:	
Date of birth:	Age:	Sex: Male	Female
Contact telephone number/s:	Occupation:		
Physical home address:			

ATTENDING HEALTHCARE WORKER AND HEALTHCARE FACILITY DETAILS

Name of clinician:	Contact number/s of clinician:	
Healthcare facility name:	Location of healthcare facility:	
Hospital number:	Date of admission (dd/mm/yyyy):	Ward:

RISK FACTORS/ EXPOSURE HISTORY – during the 21 days prior to onset of symptoms

Travelled to a country endemic for monkeypox*	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Close contact with suspected or confirmed case of monkeypox**	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
History of international travel	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
None of the above	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>

CLINICAL INFORMATION
A. Date of onset of illness (dd/mm/yyyy):
B. Clinical features (Tick appropriate box: yes, no, unknown)

Fever Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> If yes, specify temperature _____ °C	Rash Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Date of onset of rash (dd/mm/yyyy): _____
Lymphadenopathy Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Headache Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Muscle pain Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Fatigue Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Sore throat Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Nausea/vomiting Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Cough Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Chills/sweats Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Oral ulcers Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Light sensitivity Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____	If yes, specify <u>Distribution of rash:</u> Face <input type="checkbox"/> Legs <input type="checkbox"/> Soles of the feet <input type="checkbox"/> Trunk <input type="checkbox"/> Arms <input type="checkbox"/> Palms of hands <input type="checkbox"/> Thorax <input type="checkbox"/> Genitals <input type="checkbox"/> All over body <input type="checkbox"/> <u>Type of rash:</u> Macular Yes <input type="checkbox"/> No <input type="checkbox"/> Maculopapular Yes <input type="checkbox"/> No <input type="checkbox"/> Vesicular Yes <input type="checkbox"/> No <input type="checkbox"/> Petechial Yes <input type="checkbox"/> No <input type="checkbox"/> Vasculitic Yes <input type="checkbox"/> No <input type="checkbox"/>
If female, pregnant Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	

PAST MEDICAL AND TRAVEL HISTORY

Underlying illness*** :	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
If yes, give details:			

Travel outside of South Africa in the 21 days prior to onset of illness? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>				
If yes, details:				
Country visited (indicate if travelling in transit through airport in another country)	Location/s visited within country:	Date of arrival (dd/mm/yyyy):	Date of departure (dd/mm/yyyy):	Activities at the location

Footnotes:

* Countries endemic for monkeypox:

- Cameroon
- Central African Republic
- Congo
- Democratic Republic of Congo
- Gabon
- Ghana
- Ivory Coast
- Liberia
- Nigeria
- Sierra Leone
- South Sudan

**Initiate contact tracing in collaboration with your infection control practitioner and local communicable diseases control coordinator

*** Any immunosuppressing conditions, including active HIV disease

